Interagency Collaboration and Services Integration Commission
Annual Report

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Introduction

The Interagency Collaboration and Services Integration Commission (the Commission) was established in Title V of the Public Education Reform Amendment Act of 2007. Addressing the broad range of needs of students, both in- and outside of the classroom is a critical piece of the Mayor's comprehensive school reform agenda. The Commission was developed to foster and strengthen collaboration among agencies, thereby improving outcomes for children and families in the District of Columbia.

The legislation requires that the Commission, staffed and directed by the Office of the Deputy Mayor for Education (DME), identify and pilot evidence-based programs. According to the National Registry of Evidence-based Programs and Practices (NREPP), evidence-based programs are "approaches to prevention or treatment that are validated by some form of documented scientific evidence. Evidence often is defined as findings established through scientific research, such as controlled clinical studies, but other methods of establishing evidence are considered valid as well." In order to ensure that such programs are maximally effective, the legislation adopted a restrictive definition of evidence-based practices (Section 502(3)), limiting the Commission's choices to those programs that had been "affirmatively evaluated by an independent agency with demonstrated expertise in evaluation," that had "demonstrate[d] effectiveness in accomplishing its intended purposes," and had been successfully "replicated in other communities." The legislation also clearly identifies areas of need where interventions shall be piloted (Section 505(b)(1)). Those areas include: early childhood psycho-social and emotional development assistance; school-based violence and substance abuse prevention; social and emotional learning assistance; family resiliency and strengthening assistance; and services that are designed to reduce local reliance on out-of-home placement of children under the age of 18. Additionally, the Commission was established to increase the capacity and maximize the resources and impact of the District's child and family serving agencies.

The Commission has selected early intervention and prevention programs for piloting that are most likely to minimize destructive and dysfunctional behavior. Most of these programs involve the activities of multiple member agencies. Through the Commission, the DME has provided critical strategic planning and implementation services to facilitate the rollout of its initiatives and to ensure the efficacy and reach of programs, particularly the coordination of program activities. Where appropriate, cross-agency training and technical assistance is also provided to promote and monitor for fidelity of implementation.

The 2009 calendar year included completion of the first full school year of implementation of initial pilot programs and, for school year 2009-2010, expansion of services to additional schools, and roll-out of two new pilot programs targeting early childhood development and school culture.

DC START

Program Overview

DC START is a research-based model for providing school mental health services using a system-of-care approach to the delivery of human services. DC START is designed primarily to foster positive social, emotional, and educational development. Because it is grounded in the science of what works, DC START has a strong record of promoting positive social and emotional outcomes, as well as engendering student resilience. DC START addresses issues that many young students face, such as anger management difficulties, behavior/conduct problems, depression, anxiety, alcohol and other drug issues, feelings of isolation, excessive shyness, serious aggressiveness with peers or family, chronic school absences, feelings of worthlessness, or sudden changes in personality. To deal with these concerns, DC START provides a highly structured set of interventions for elementary school and middle school-age children with complex needs. In addition, DC START clinicians work closely with family members, identifying unmet service needs and assisting family members in accessing available, community-based programs and services.

Launched as a pilot program in two District of Columbia Public Schools (DCPS) in April 2008**,** DC START includes the four core programmatic components required by Title V of the Public Education Reform Amendment Act of 2007:

1. Multidisciplinary screening and assessment of participants;
2. Development of integrated service plans for clients and their families;
3. Clinicians use of one of two evidence-based therapeutic interventions—Cognitive Behavioral Therapy (CBT) and Child-Centered Play Therapy (CCPT)—depending on the child's age and level of development; and
4. Documentation and monitoring of service delivery using an interagency database that promotes fidelity to the DC START model and program accountability, known as the Children At-Risk Interagency (CHARI) database.

Implementation Status

DC START began as a pilot program providing services in April 2008 at Barnard Elementary School and Truesdell Educational Campus. In August 2008, DC START expanded services to five additional schools: Leckie, Malcolm X, Martin Luther King and Simon Elementary Schools, and MacFarland Middle School. From March 2008 to June 2009, DC START clinicians closed 112 completed cases. Completed cases include those for which clients have been through the pre/post-assessment process and all 21 sessions of counseling.

DC START clinicians are provided ongoing professional training and clinical supervision to promote continuous improvement of diagnostic and counseling skills. Local field experts provide 90-minute training sessions on Cognitive Behavioral Therapy (CBT) and Child-Centered Play Therapy (CCPT) monthly.

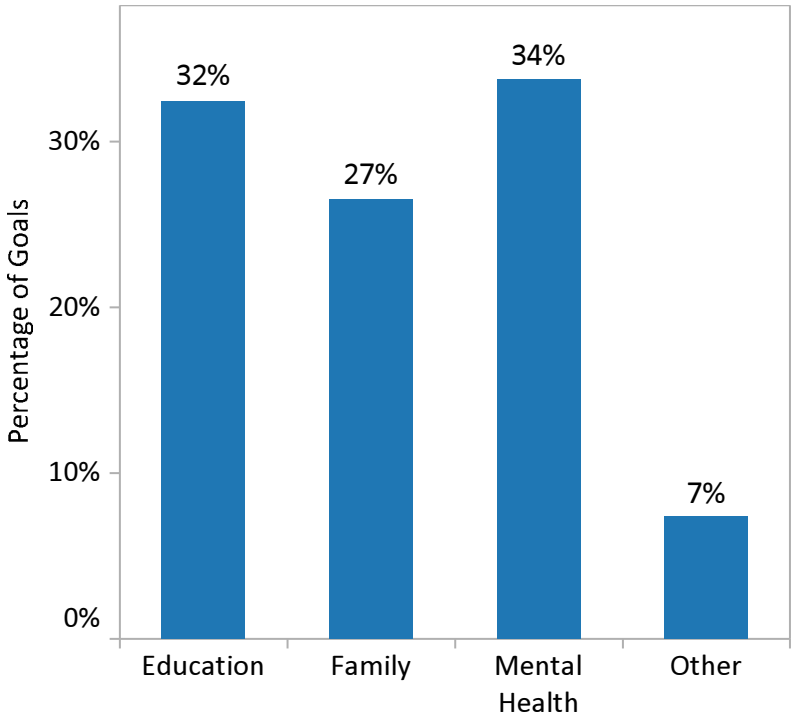
Principals at each school report exceptionally good relationships with DC START clinicians, with whom they communicate with at least once per week. Principals also report that the

clinicians have become integral parts of the school communities, collaborating well with the school staff and demonstrating a high level of competence and professionalism. Of the six principals interviewed, five reported being "very satisfied" with the DC START program, and one reported being "moderately satisfied."

To monitor fidelity to evidence-based counseling techniques and to improve clinical skills, DC START clinicians complete implementation checklists for both CBT and CCPT semi-annually. Data from these checklists help the DC START Coordinator, clinicians, and trainers ascertain the extent to which DC START clinicians adhere to the evidence-based therapeutic practices of CBT and CCPT. An analysis of these checklists indicates that clinicians are implementing the complex array of strategies and practices associated with CBT and CCPT with a high level of competence and consistency. In the event that either individual clinicians or the entire coterie indicate a certain deficit in relevant skills or practices, the DC START Coordinator organizes targeted training with the trainers.

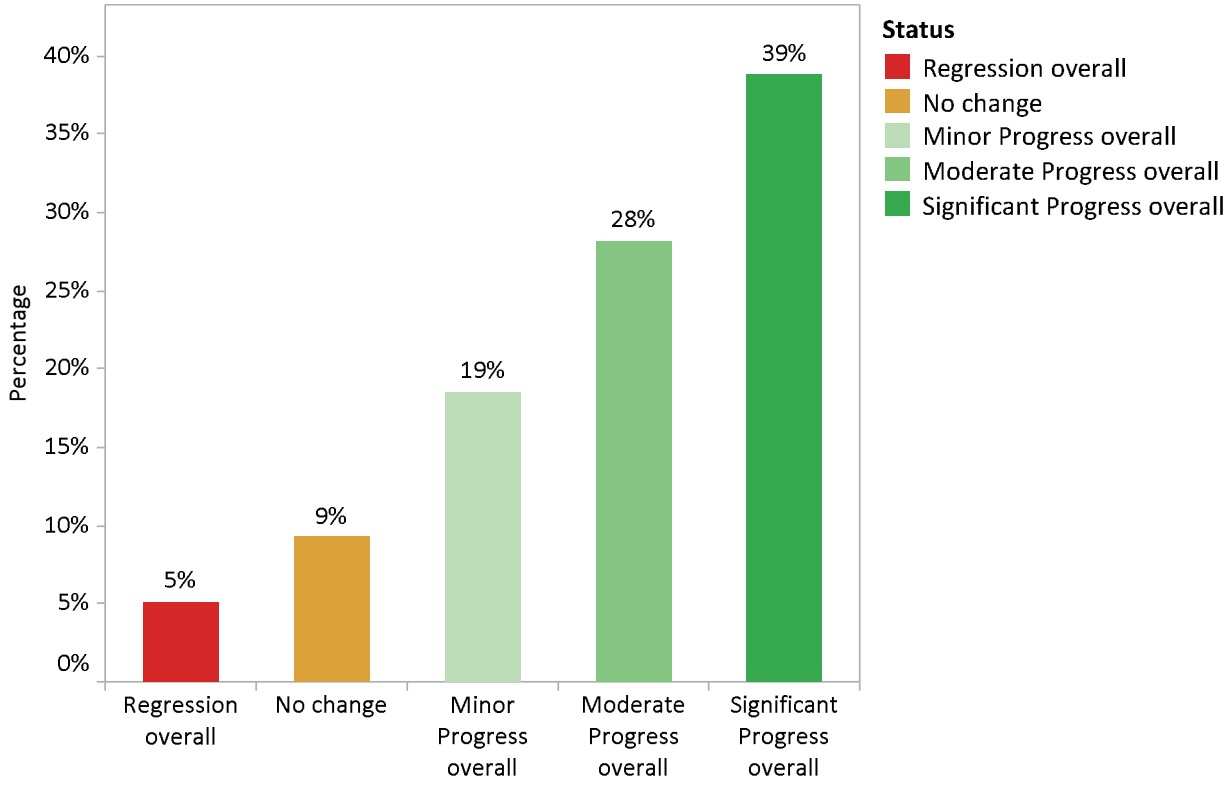
In addition to the high standards of training and supervision the DC START clinicians receive, DC START is distinct from other school-based mental health programs in their quality approach to multidisciplinary assessments and development of integrated service plans that meet students' and families' specific identified needs. The Wellbeing Assessment Tool, adopted by the Commission after a review by an expert panel, employs a variety of sources of information to determine resiliencies and risks of students referred for services and their families. The instrument supports clinicians as they meet with families in their homes to identify unmet service needs and to detail the underlying issues that result in the problematic or dysfunctional behavior of the student clients. Data stored in CHARI (the interagency database implemented by the Commission to assist clinicians in maintaining fidelity to the model and to promote a high level of accountability) shows that DC START clinicians address mental health issues, as well as a wide range of other issues including alcohol/substance abuse, family, employment and legal issues. DC START clinicians develop treatment goals with clients and their household members. Figure 1 shows these treatment goals. In the District, and in other evaluations of the DC START model, data shows that students are confronting a variety of different issues.

Figure 1 – Goals by domain



For closed and completed cases, where children have received the entire course of treatment and where, among other activities, integrated services plans have been developed and implemented for the household, a significant majority of students are making important strides toward meeting treatment goals. Figure 2 shows that students made moderate to significant progress toward meeting 67 percent of the 291 treatment goals established by DC START clinicians for their clients. As a general rule, children with significant presenting problems will, absent a timely and appropriate intervention, begin to decompensate, that is, exhibit more severe symptoms. The results of this analysis of DC START data indicate that student clients improved through the program. This was true for all types of treatment goals, particularly with regard to education goals. Students made moderate to substantial progress toward meeting 82 percent of education treatment goals in closed and completed DC START cases; only six percent showed any form of regression in this area during treatment.

Figure 2 – Progress made towards meeting all treatment goals (N=291)



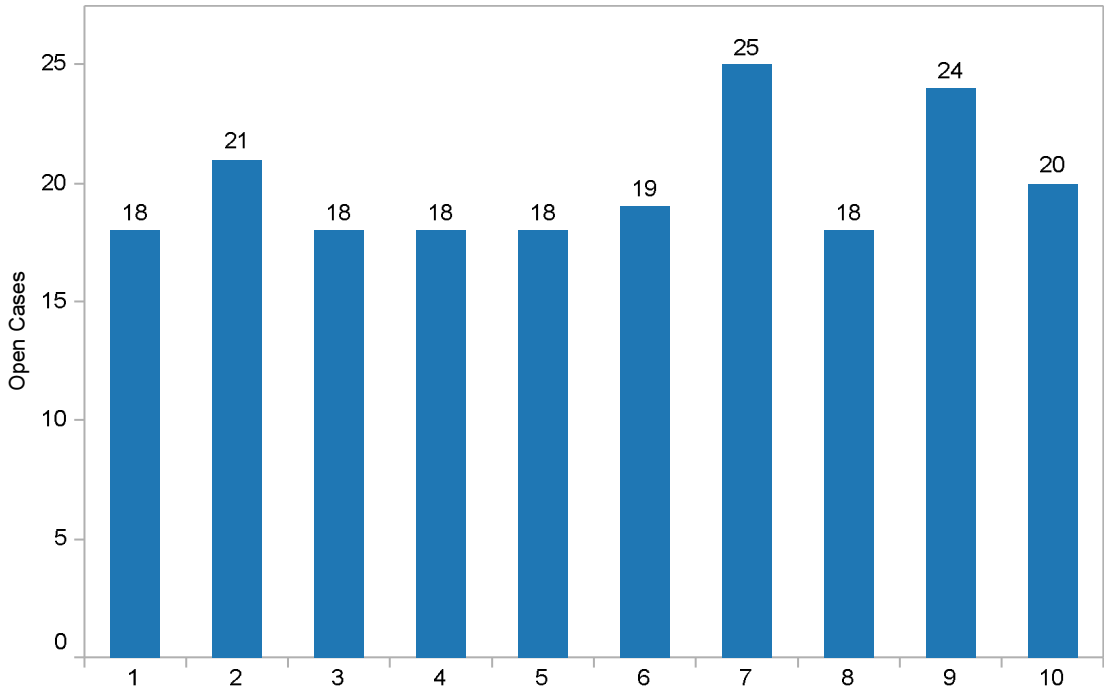
School Year 2009-10 Expansion

DC START expanded again in August 2009 to include four new sites: Amidon Elementary School and the Brookland, Burroughs and West Educational Campuses. In addition, DC START services were discontinued at Martin Luther King Elementary. As in 2008, representatives from the DME and the DC START Coordinator facilitated program implementation with site visits, which included reviews of program referral and treatment protocols and identification of appropriate office space for the clinicians with school administrators.

To support new schools, three additional clinicians were hired. Each of the new clinicians holds a Masters degree in Social Work and is licensed. As in 2008, clinicians participated in comprehensive staff training, including: three days of intensive work in both Cognitive Behavioral and Child-Centered Play Therapy, and four days on the protocols and practices of DC START model (including use of the Observation Checklist screening protocol, the WellBeing Assessment Tool, and the Commission Consent and Waiver process) and use of the CHARI database.

Figure 3 shows open cases at all ten schools in mid-November 2009. During this time DC START clinician caseloads were at least 77% of their capacity. On average, clinicians had 19 open cases, with a maximum capacity of 23-25 cases (depending on the intensity of service needs of the clients).

Figure 3 – Open DC START Cases by School (November 2009)



Primary Project

Program Overview

Primary Project (formerly known as Primary Mental Health Project) is a school-based early intervention program that promotes the positive school adjustment of kindergarten through third grade by addressing developing social and emotional problems before they become significant impediments to normative development. Using play and responsive listening techniques, paraprofessional called Child Associates, who are closely supervised by mental health

professionals, support the age-appropriate and positive development of children at risk of developing more significant mental health problems.

Primary Project is a well established program whose cultural competence and applicability to students in urban environments has been demonstrated in numerous studies. It was recognized as one of the nation's five exemplary prevention programs in the *U.S. Surgeon General's Report on Mental Health* (December 1999). It is listed both on the *National Registry of Evidence-based Programs and Practices* of the Substance Abuse and Mental Health Services Administration (SAMHSA) and on the *Model Programs Guide* of the U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention.

Current Implementation

In DC, Primary Project works as a partnership between DCPS, the Department of Mental Health (DMH) and the Deputy Mayor's Office. During the 2008-09 school year, Primary Project served students in 11 DCPS schools and one public charter school: Aiton, Burrville, Garrison, Miner, Stanton, MC Terrell/McGogney, Tubman, Turner at Green and Webb/Wheatley Elementary Schools, Browne and Thurgood Marshall Educational Campuses and Meridian Public Charter School.

Teachers complete a validated early screening instrument to identify children at risk who will benefit from this preventive intervention, including children who are acting out, display mild aggression, are anxious or withdrawn, or have behavioral issues that interfere with learning. Nearly 1,000 kindergarten and first grade students were screened in the program. Of that number more than one third screened eligible for Primary Project services, and 166 received services. The core of the intervention is an ongoing, non-directive relationship with the Child Associate, who meets with the student weekly in 45-minute sessions over a 12 to 15-week period. The weekly sessions occur on a one-to-one basis in a structured playroom environment. The Child Associates are trained to implement expressive play and responsive listening techniques which reinforce the resilience and self-regulatory skills of participating children. Emerging issues and the response of students to the program are monitored during regular meetings between the Child Associate and mental health professionals from DMH.

A majority of principals in schools with Primary Project reported satisfaction with the program and acknowledged its utility. The parent organization of Primary Project (Children's Institute), in conjunction with DMH, DCPS, and DME, collected pre- and post-intervention data to evaluate the effectiveness of Primary Project using the Teacher-Child Rating Scale (T-CRS). The T-CRS is a validated observation instrument that provides an accurate measure of a child's social-emotional wellbeing and adjustment to a school setting. During its first year of implementation, Primary Project was a tremendous success. On average, the program had a positive and statistically significant effect on participants ($p \leq 0.10$) on all four scales of the T-CRS (Table 4):

1) Task orientation, which assesses a child's skills necessary to succeed in the school environment;
2) Behavior control, which assesses a child's skills in tolerating and adapting to limits;

3) Assertiveness, which measures a child's interpersonal functioning and confidence; and
4) Peer social skills, which measures a child's ability to interact with peers in an age-appropriate way.

Table 4 – Percent Change in Mean T-CRS Scores, 2008-2009 School Year

T-CRS Scales	% Change in Mean Scores
Task orientation	6%
Behavior control	4%
Assertiveness	5%
Peer sociability	5%

These pilot year results are encouraging and the data are in keeping with results in other comparable urban districts, which also show that average T-CRS scores remain stable or decline for children who are eligible for Primary Project services but do not receive the intervention.

School Year 2009-10 Expansion & Improvements

In addition to continuing to serve the schools listed above, Primary Project began to serve students at Eagle Academy Public Charter School during the 2009-10 school year. In February 2010, Primary Project will expand again to serve students at Simon, Moten-Wilkenson, and Randle Highlands Elementary Schools with funding from Project LAUNCH (Linking Action for Unmet Needs in Children's Health), a federal grant recently awarded to the District Department of Health.

Additionally, during the current school year, teachers and Child Associates began using a web-based system called COMET to complete screens. Replacing a paper-based system, COMET has created a more efficient screening and assessment process, reducing the time between screens being completed and students receiving services and easing the administrative burden on Primary Project's Program Manager.

Second Step

Program Overview

Second Step is an evidence-based violence prevention curriculum designed to reduce impulsive and aggressive behavior of elementary and middle school students. The curriculum is designed to promote three essential social/emotional competencies: a) the capacity to feel and express empathy; b) impulse control and problem solving; and c) anger management. As the curriculum's lessons are integrated into the classroom, students are taught a range of social and emotional skills that reduce high-risk and aggressive behaviors and increase the capacity of the student to self-regulate and to behave more pro-socially. When implemented as intended by most or all of the instructional staff in an elementary or middle school building, Second Step results in

more manageable classrooms, reduced fighting and bullying, and, in general, an improved school climate.

Teachers are trained to use the curriculum's scope and sequence of lessons to draw children's attention to the positive results of their empathetic and prosocial behaviors. The program uses peer interactions and adult modeling to foster the development of a positive identity. The net result of implementing Second Step is an improved school culture that integrates academics with social and emotional learning. Lessons are taught once or twice a week. Group discussion, modeling, coaching, and practice are used to increase students' social/emotional competencies, risk assessment skills, decision-making ability, self-regulation, and positive goal setting.

Second Step has been recognized by several leading institutions as a culturally competent program with proven efficacy in urban communities. It received an "exemplary" rating from the U.S. Department of Education's 2001 Expert Panel on Safe, Disciplined, and Drug-Free Schools and is included in the Substance Abuse and Mental Health Services Administration's *National Registry of Evidence-based Programs and Practice* and the *Model Programs Guide* of the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention.

Current Implementation of Second Step

The DME began piloting Second Step during the 2008-09 school year in sixteen Educational Campuses (school sites that serve students from pre-kindergarten to eighth grade):

- Brightwood Educational Campus
- Browne Educational Campus
- Burroughs Educational Campus
- Emery Educational Campus
- Francis-Stevens Educational Campus
- Langdon Educational Campus
- LaSalle-Backus Educational Campus
- Marshall Educational Campus
- Noyes Educational Campus
- Raymond Educational Campus
- Shaed Educational Campus
- Takoma Educational Campus
- Truesdell Educational Campus
- Walker-Jones Educational Campus
- West Educational Campus
- Whittier Educational Campus

Of the 16 schools selected for piloting Second Step, Noyes elected to withdraw from the pilot at the start of the 2009-10 school year, after struggling to participate in the trainings, and two other schools failed to participate in a meaningful manner, sending only a handful of teachers to the trainings. These two schools will participate in trainings conducted in 2010. Between August 2008 and December 2009, nearly 240 teachers and support staff from 15 Educational Campuses were trained in Second Step, representing 57% of the teachers in these buildings. Additionally, staff, including administrators and mental health professionals, in each school were trained to provide building-level support.

A majority of principals report satisfaction with Second Step and are finding the curriculum to be effective. The remaining principals indicated that the program has not been in their building long enough to gauge impact.

As of mid-November, it is anticipated that 135 of 210 teachers in the 13 schools with a significant percentage of staff trained will offer the entire curriculum to their students, impacting an estimated 3087 students. In order to ensure consistent implementation with fidelity to the curriculum's design, the DME monitors implementation and provides technical assistance to each school on a monthly basis. This includes working with school staff to set monthly and yearly goals for the program, observing lessons being taught and providing feedback, co-teaching, encouraging administrative support, and, where necessary, ensuring equitable access to curriculum materials.

Next Steps

During the 2010 summer, a cadre of forty teachers, as well as administrators and staff from the Chancellor's Office and the DME, will be trained as turnkey trainers for Second Step, providing schools and DCPS central office the capacity to sustain the program by training new teachers and supporting the efforts of ongoing instructional staff with targeted technical assistance. The DME intends to train at least two staff persons at each pilot school. Selected staff will be leaders within the school, and will have implemented Second Step with fidelity and success in their classrooms.

LifeSkills Training

Program Overview

LifeSkills Training (LST) is a classroom-based drug use prevention program for upper elementary, junior high school, and high school students. A validated and widely replicated program, LST is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The LST approach is based on current research which indicates that teaching general personal and social skills in combination with drug resistance skills and normative education is likely to reduce use of tobacco, alcohol, and other drugs by children and adolescents. Among its demonstrated effects, the LST curriculum:

- Promotes skills necessary to resist social pressures to drink alcohol, smoke cigarettes, and use drugs
- Helps youth develop greater self-esteem, self-mastery, and self-confidence
- Increases knowledge of the immediate consequences of substance abuse
- Provides students with tools to cope effectively with social anxiety
- Enhances cognitive and behavioral competencies to prevent and reduce a variety of health risk behaviors

LifeSkills Training is widely regarded as an effective prevention approach. It is among the most extensively researched prevention programs in the country. It has been recognized as a proven, research-based model by the National Institute on Drug Abuse, the White House Office of National Drug Control Policy, the U.S Department of Education, the American Medical Association, the American Psychological Association, the National Centers for Disease Control, and the Center for Substance Abuse Prevention of the U.S. Department of Health and Human Services.

Current Implementation

The LifeSkills Training pilot began during the summer of 2008. Two to three staff persons in each building, including social workers, mental health professionals, and health teachers, were trained in middle schools. Shortly thereafter, DCPS' Office of Youth Engagement made LifeSkills Training the substance abuse prevention program of the DCPS health curriculum. During the summer of 2009, DCPS revised the pacing guides for high school health teachers to include LifeSkills Training as a key component in the curriculum.

To date, 21 of 30 educational campuses, 20 of 25 middle school and 35 of 42 high school health teachers have been trained in the curriculum. During the 2009-10 school year, it is anticipated that 1670 students will receive the middle school curriculum and 2877 will receive the high school curriculum. Teachers report that students are engaged by the program, its interactive videos, and its workbooks.

Next Steps

Over the next calendar year, the DME will hold a training of trainers to increase the internal capacity at DCPS to implement the program. A cadre of ten high-performing teachers will be selected to become trainers in LST for their peers.

School Resource Officer Training

Program Overview

A School Resource Officer (SRO) is a law enforcement officer who has been specially trained to apply the philosophy, principles, and practices of community policing to schools. He or she has three interrelated goals: 1) prevent juvenile delinquency and crime, 2) promote a positive school climate, and 3) help youth develop the attitudes and life skills they need to become law-abiding, contributing members of their community. In consultation with the Metropolitan Police Department (MPD) and DCPS, the DME engaged an experienced trainer to train MPD SROs in research-based SRO activities and to provide ongoing technical assistance to support their implementation. These activities included mentoring, providing law-related education, conducting school safety audits, using CPTED (Crime Prevention Through Environmental Design) strategies to improve school safety, coordinating the school's emergency preparedness program, and effective techniques for serving as a first responder in schools.

Current Implementation

During the fall of 2008, SROs were trained in these research-based activities. Throughout the 2008-09 school year, the trainer provided technical assistance to officers. This included observing SROs in the school and teaching in the classroom and providing feedback to strengthen their skills, and working with SROs to complete safety audits in assigned schools.

Over half of the SROs who received training completed or participated in a safety audit in their building. One-third of those officers reported that remediation activities were undertaken by school officials as a result of their audit. This involved, most often, repairs to facilities such as locks being changed or replaced and cameras made operational. Three-quarters of the SROs who received CPTED training indicated that they understood the techniques of the preventive strategy and were employing them to good effect, reducing opportunities for violent or criminal activities and increasing their capacity to conduct surveillance with ease and without undue obtrusiveness.

As a result of the training, SROs reported, in a survey conducted late in the 2008-2009 academic year, that their relationships with students had improved, marked, in particular, by increased trust of youth in law enforcement and more routine communication between students and police. As a result of employing these techniques, officers noted a decrease in overall assaults in schools.

Next Steps

Over the next calendar year, the DME and MPD will continue to work on a process that permits MPD to internalize the SRO training program. The DME also plans to continue providing technical assistance to SROs and to educate administrators in both DCPS and charter schools on Crime Prevention through Environmental Design techniques.

Therapeutic Crisis Intervention System

Program Overview

Therapeutic Crisis Intervention (TCI) is an evidence-based initiative developed by the Family Life Development Center as a part of the Residential Child Care Project at Cornell University in the early 1980s. With its intensive training program, TCI prepares school staff to implement a range of proven strategies to monitor, prevent, and effectively intervene in violent or other substantially disruptive incidents. TCI's strategies assist school staff to: prevent crises from occurring; de-escalate potential crises; manage acute crises effectively; reduce potential and actual injuries to students and staff; and learn constructive ways to handle stressful situations. The training program provides school staff with the skills, knowledge, and confidence to work effectively with children in crisis. It focuses on preventative strategies including early intervention, de-escalation, behavior management, communication, and the development of coping skills.

An effective crisis prevention and management system, TCI has a wide range of positive outcomes. It promotes a calmer school climate by significantly reducing fighting, serious verbal threats and physical assaults. By improving the confidence and skills of staff to engage in collaborative solutions to de-escalate and cope with crises, TCI also reduces reliance on physical restraint and increases the capacity of staff to develop team approaches to building and maintaining a positive school climate.

Current Implementation

Eight DCPS schools were selected to participate in the pilot TCI project: Coolidge, Dunbar, Roosevelt, Spingarn and Wilson Senior High Schools; Hamilton-Moten and Shadd Transition

Academies; and Jackie Robinson Center. In July 2009, three to five teachers and/or administrators from each of the pilot schools were trained and certified by Cornell University staff to be TCI Trainers. In order to earn the certification, participants were required to successfully complete a five-day training course, agree to practice the principles that were taught during the course, pass both written and skill demonstration tests, and train colleagues at their schools in TCI strategies and techniques. Of the 30 DCPS participants eligible to take the TCI test, 27 were certified.

In August 2009, turnkey training began in earnest. One hundred staff from all eight schools participated in TCI trainings. Additionally, three schools held a second direct training in September. In October, Cornell TCI staff provided technical assistance in all eight schools. In November 2009, Dunbar Senior High School, which is under the leadership of Friends of Bedford, elected to discontinue its participation in the program because TCI does not align with their specific turnaround model.

In January 2010, Cornell provided two one-day workshops to address two additional domains in the TCI model – clinical participation and leadership. The first workshop, Individual Crisis Management Plans, was designed to help TCI trainers and clinical staff to prevent and monitor crises through a formalized process called the individual crisis management plan (ICMP). Through the process of the ICMP, school staff completes a functional analysis of the child's behavior and develop a plan to prevent the student from engaging in high risk behavior. The second workshop, Post Crisis Response and Supervision, was geared towards TCI trainers and building administrators. This workshop helped supervisors develop tools to support teachers and clinical staff in preventing and de-escalating crises, and in responding effectively to bring a school back to a higher level of functioning.

Next Steps

The Cornell University team continues to provide on-site technical assistance to the six remaining pilot schools (Jackie Robinson center will close at the end of the 2009-2010 school year). On-site technical assistance is shaped to meet the needs of the school, but can include classroom observations and feedback for teachers regarding their use of TCI techniques, direction and feedback in developing both ICMPs and a system for implementing ICMPs, or co-facilitation of focused refresher workshops so that trained staff have an opportunity to practice techniques in a structured space.

Early Childhood Mental Health Consultation

Program Overview

Early Childhood Mental Health Consultation (ECMHC) is designed to improve the ability of those involved with early childhood development – from staff to families – to prevent, identify, treat, and reduce the impact of social and emotional issues on a child and the classroom.

Current Implementation

ECMHC, called the *Healthy Futures* program in the District, is a partnership between the Department of Health (DOH), DMH, the Office of the State Superintendent for Education (OSSE), the Commission, and the Early Childhood Comprehensive System (ECCS). The project demonstrates true interagency collaboration and is funded and supported by the Commission, the Mental Health Block Grant and Project LAUNCH.

Healthy Futures provides both child/family-centered consultation and programmatic consultation. With child/family-centered consultation, licensed mental health professionals and child development center staff are able to bring expertise in each of their fields to the table and work collaboratively with the family to develop a plan to improve the child's functioning in the center and at home. Mental health specialists providing programmatic consultation also work with child development centers on issues that impact the centers more broadly, such as setting conditions.

Healthy Futures began during the 2010 fiscal year with outreach to identified centers. Interested facilities completed an initial application and participated in an interview and site-visit. While participating sites are in the process of being identified, preference will be given to those that are accredited, have a minimum of 50 students, and enroll infants.

In order to evaluate the effectiveness of the consultation, 32 child development centers will be selected to participate over the course of two years. Sixteen centers will participate during the first year, and, contingent on the availability of funding, sixteen additional centers will be added during the second year, providing a control group for evaluation.

DMH is currently in the process of hiring mental health professionals with experience in early childhood development for the consultant positions. To increase ECMHC's reach, the partners worked with the University of Maryland, Baltimore – Center for Infant Study to offer 5-day certification in Early Childhood Mental Health Certification to the District's early childhood development community. Twenty-five staff members with backgrounds in early childhood and/or mental health were able to participate in this training and receive certification.

Conclusion

Currently the Commission supports seven evidence-based programs coordinated and managed by the DME. During the 2009 fiscal year, 639 teachers were trained though the Commission and those programs impacted 13,025 students in nearly 80 schools. By design, the DME's unique position outside of an agency or school system gives them the ability to pilot, incubate, and prioritize evidence-based programs. Thus, as these programs are proven to be effective, the DME will continue to implement its plan to transition programs to the agency best positioned to support their success in the long-term. Beyond the current fiscal year, DC START, Second Step, and LifeSkills Training are planned to continue under the leadership and support of DCPS' Office of Youth Engagement. DMH and DCPS plan to own Primary Project collaboratively, while MPD will continue with SRO training.